

## **Exhibit 5a**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10/25/05 1400	<p>5 c/o cold on 1 lip x 1 week. and hyperpigmentation</p> <p>(1) 34gmatic area of face p "blackhead burst"</p> <p>0 22yo AA ♂ NAD</p> <p>(2) 34gmatic area linear hyperpigmentation</p> <p>• distinct edges. No raised area, no acne noted. (Will print to monitor)</p> <p>HSV 1 c center cleft lip → right lip to cleft healing, flat papule of drainage &lt; 5mm flesh colored</p> <p>A HSV 1</p> <p>Hyperpigmentation les. on</p> <p>P Education - above E. HUGHES, APRN, BC-FNP <i>EHA</i></p> <p>PRAD</p>
11/9/06 1250	<p>5/ Sick call- Since last Monday (7 days) has</p> <p>9% rash on stomach and arms. Ate sunflower seeds and cheese from Commissary. Developed rash after this time frame Denies bites. Rash is itchy esp at night. Denies any change in soaps, detergent or lotions.</p> <p>0/ Trunk (arms and upper thighs) diffuse flat hyperpigmented rash both front and back. Has larger "mother" lesion on (L) side of neck</p> <p>A Pityriasis rosacea</p> <p>P/ Dr Marini consulted. Pt educated that rash could take 6-12 weeks to clear.</p> <p>Hydroxyzine 50 mg qHS... pillerline x 30d.</p>

Ord. Date 01/09/06 BROWN, DEMETRIUS E. SWEATT:10  
21534-039 (0)Refills  
Exp. Date 02/07/08 \*\*\*PILL LINE\*\*\* TAKE TWO TABLETS (50MG) @ 1830  
Rx # 368326 HYDROXYZINE 25 MG TAB #2

INFORMED WITH E. SWEATT, RPA, AHSA

SN 7540-00-634-4176

600-108

## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

3/2/05  
0930

## ANNUAL FOOD HANDLER'S EXAMINATION

S) Any symptoms or history of:

1: Acute or chronic inflammatory conditions of the respiratory system (active TB, cough, etc)?

☐ Yes ☒ No

2: Acute or chronic infections, skin diseases, open sores?

☐ Yes ☒ No

3: Acute or chronic intestinal infections (diarrhea, etc.)?

☐ Yes ☒ No

4: Any communicable diseases (HIV, Hepatitis B, Hepatitis C, etc.)?

☐ Yes ☒ No

Explain any yes answer to the above questions:

O) Blood Pressure: 110/78 Pulse: 64 Wt 190 Temp: 96

Pertinent, exam including: ENT, lungs, heart, abdomen and skin. WNL

A) healthy male

P) Cleared / Not Cleared for Food Service work.D. Marini, M.D.  
Clinical DirectorPATIENT'S IDENTIFICATION (Use this space for Mechanical  
mprint)RECORDS  
MAINTAINED  
AT:

PATIENT'S NAME (Last, First, Middle Initial)

Brown Demetrius

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)  
Prescribed by GSA and ICMR  
FPMR (41 CFR) 101-11.6

NSN 7540-00-834-4176

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

11-15-04

BP-149 RECEIVED AND REVIEWED

1035

AT FCI, RAY BROOK, NY ON

11-4-04

S. Kieffer

S. Kieffer, MRT

DM D. Marini, M.D.  
Clinical Director

3/11/05

⑤ Staph exposure Open / open wounds

1035

S. Kieffer

⑥ No wound exposure

⑦ S/P Staph exposure

⑧ No xx mark F/U of any

type of wound / open

exposed to staph.

Bradley R. Cink, PA-C

3.1.05

SCHEDULED FOR

2/5 Physical Per request

3/2/04 @ 1030

T. Root

T. Root, Med. Secretary

T. Root  
Med. Secretary

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

21534-039

WARD NO.

Brown, Demetrius

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

FEDERAL CORRECTIONAL INSTITUTION

PO Box 300

RAY BROOK NY 12977

STANDARD FORM 600 (REV. 8-97)

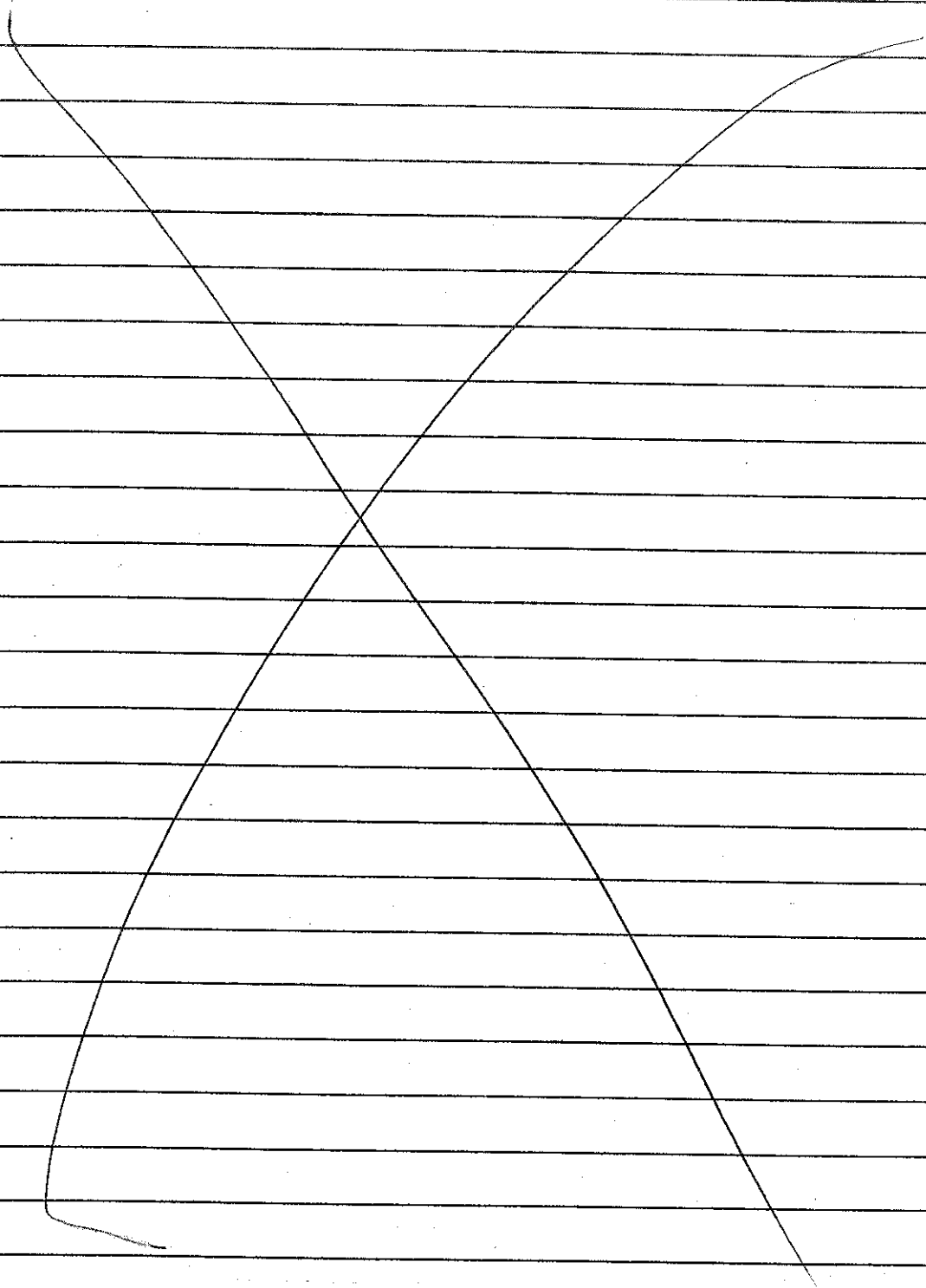
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

000003

USP LVN

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)



AUTHORIZED FOR LOCAL REPRODUCTION

Brown, Demetrius 21534-039

### Medical Record

**STANDARD FORM 600** (REV. 6-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

600005

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

*[A large handwritten 'X' is drawn across the entire table area, indicating that the information is not provided or is confidential.]*

NSN 7540-00-634-4176

500-108

## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

7-8-97

Intake screening

1000

No change in medical status.  
denies suicidal thoughts  
No meds

H.T. Georgy

MOSSAM GEORGY, FMG, PA

7/14/97

③ Fungal infec. in the toe and nail

0755

② Fungal infec. of the nail

① Fungal infec.

④ Anti-fungal cream 1/2 to be applied Bid  
Ref. X2

Pt. was educated about foot hygiene to  
understand

## PATIENT EDUCATION

☒ Dosage  
☒ Special instructions  
☒ Action  
Gelatin: 1000

W. Hammond

W. Hammond, M.P.

7/16/97

0915

Physical exam done, PPD, Tetanus inj. (done)  
given

M. Tarr

M. TARR, MLP

9/19/97

1830

See injury report

W. Hammond

W. Hammond, M.P.

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS  
MAINTAINED  
AT:

FCI McKean Health Services

PATIENT'S NAME (Last, First, Middle initial)

Brown Demetrius

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

600007

DEPART./SERVICE SSN/IDENTIFICATION NO.

21534-039

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

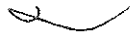
STANDARD FORM 600 (Rev. 5-84)  
Prescribed by GSA and ICMR

4/5/01

lmm

Adm: WTA

1100 ~~± D10 Depression & PTSD, put in psych clinic~~

  
D. Olson, MD  
Clinical Director

## CLINICAL RECORD

## LABORATORY REPORTS

COPY

FCI MCKEAN HEALTH SVC.

97 JUL 16 AM 9:38

FCI MCKEAN  
P.O. BOX 5000  
BRADFORD, PA 16704

FCI MCKEAN HEALTH SVC.

97 JUL 18 PM 3:03

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE

LAB. ID. NO.

D. Olsen

S. Czekai (TECH) 7/18/97

S. CZEKAI, MED. TECH.

TEST	DATE	RESULTS	REMARKS
DIFF	7/16/97	1005	
WBC	7/16/97	Normal	
PLT	7/16/97	NR	
CRP	7/16/97	NR	
ASO	7/16/97	NR	
CP	7/16/97	NR	
PTA-ABS	7/16/97	NR	
PHA	7/16/97	NR	
RHEUMATOID FACTOR	7/16/97	NR	
ANTI-NUCLEAR FACTOR (ANF)	7/16/97	NR	
COLD AGG.	7/16/97	NR	
ASO	7/16/97	NR	
CRP	7/16/97	NR	
SERUM COMPLEMENT	7/16/97	NR	
FEESLE	7/16/97	NR	
HA	7/16/97	NR	
THYROGLOBULIN ANTIBODY	7/16/97	NR	
THYROID MICROSOVAL ANTIBODY	7/16/97	NR	

BRADFORD, PA 16704

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

21534-039

WARD NO.

LABORATORY REPORTS  
Standard Form 514Prescribed by GSA/ICMR  
FIRM (51 CFR) 201-45-505  
October 1975 514-108

GPO : 1996 O - 169-817

600009

Baxter

Baxter Healthcare Corporation  
Scientific Products Division  
McKeesport, PA 15110-1000

Sysmax

Rev 9/87

COPY

Brown, Demetrios  
21534-039

FCI MCKEAN HEALTH SVC.

97 JUL 16 AM 9:38

FCI MCKEAN

P.O. BOX 5000

BRADFORD, PA 16701

FCI MCKEAN HEALTH SVC.

97 JUL 16

PM 12:37

SPECIMEN/LAB RPT NO.

## URINALYSIS

URGENCY

☐ ROUTINE☐ PRE-OP

PATIENT STATUS

☐ BED☒ OUTPATIENT☐ DOM

SPECIMEN SOURCE

☐ ROUTINE☐ OTHER (Specify)

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD

DATE

LAB. ID NO.

D. Olson

S. Czekai

TECH 7/16/97

REMARKS

S. CZEKAI, MED. TECH.

TEST  
URINALYSIS  
SPECIMEN TAKEN  
DATE  
TIME  
RESULTS  
ROUTINE  
COLOR  
SPECIFIC GRAVITY  
UROBILINOGEN  
OCULT BLOOD  
BHE  
KETONES  
GLUCOSE  
PROTEIN  
PH  
MICROSCOPIC  
WBC  
RBC  
EPITH CELLS  
WBC  
RBC  
HYALINE  
GRANULES  
BACTERIA, M.D.  
YEASTS, M.D.  
MUCUS  
NITRITE  
BENCE-JONES PROTEIN  
HEMOGLOBIN  
HCG

TESTS

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GLUCOSE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

21534-039

WARD NO.

LABORATORY REPORTS  
Standard Form 514Prescribed by GSA/ICMR  
FPMR (41 CFR) 201-45.505  
October 1975 514-108

GPO : 1996 O - 169-817

600010

Baxter

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Scientific Products Division  
Muhlenberg Park IL 60085-6787 USA Rev 9/87

Sysmex

COPY

ATTACH 3D REPORT ALONG HERE ↑ AND SUCCEEDING ONES ON ABOVE LINES

ATTACH 2D REPORT WITH TOP AT THIS LINE ↑

ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↑

ROUTINE DIFF RBC HGB HCT WBC PLT TECH		DATE 7/16/97		DATE 7/16/97		MARGIN	
ORDERED BY Dr. Olson		S. CZEKAI, MED. TECH.		S. CZEKAI, MT			
TEST		WBC		Lymph %		Sample No.	
		RBC		Mixed %			
		HGB		Neut %			
		HCT		Lymph x 10 <sup>9</sup>			
		MCV		Mixed %			
		MCH		Neut x 10 <sup>9</sup>			
		MCHC		RDW			
		RT		TL			
		Seg		MPV			
		Band		TL			
		Lymph					
		Monoc					
		Eosino					
		Baso					
		Myelo					
		Meta					
		Pro					
		Blast					
		Retic					

7/16/97

D. OLSON M.D.

FCI MCKEAN HEALTH SVC.

97 JUL 16 AM 11:22

FCI MCKEAN  
P.O. BOX 5000  
BRADFORD, PA 16701

Baxter

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Scientific Products Division  
McGraw Park, IL 60085-6787 USA Rev. 9/87

Sysmex

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21534-039

WARD NO.

LABORATORY REPORTS  
Standard Form 514Prescribed by GSA/ICMR  
FPMR (41 CFR) 201-45.505  
October 1975 514-108

GPO : 1996 O - 169-817

600011

PATIENT IDENTIFICATION (For typed or written entries give:  
Name — last, first, middle, Medical Facility)

Brown Demetrios

2-8-72

AGE SEX SSN (Spouse)

25 M

21534-c39

EXAMINATION REQUESTED (Use of 519-B for multiple exams)

CXR

REQUESTED BY

HUBER

TELEPHONE NO.

LOCATION OF MEDICAL RECORDS

FILM NO.

DATE REQUESTED

PREGNANT

☐ YES

☐ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

T.B. SCREENING

DATE OF EXAMINATION (Month, day, year)

6/15/97

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

MATT THOMPSON, RT  
FEDERAL TRANSFER CENTER, OKC

COPY

SIGNATURE

LOCATION OF RADIOLOGIC FACILITY

1 - MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

U.S. GOVERNMENT PRINTING OFFICE: 1996-414-367

STANDARD FORM 519-A (REV. 8-83)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-45.505

01/11/11

THANK YOU FOR REFERRING THIS PATIENT

600012

HILLCREST HEALTH CENTER  
2129 S.W. 59th  
Oklahoma City, Oklahoma 73119  
(405) 680-2181  
X-RAY REPORT

FEDERAL TRANSFER CENTER

XR. NO. 21534-039

NAME  
BROWN, DEMETRIUS

ADDRESS:

STATUS

AGE  
25 MDATE  
06/19/97

ADMIT#:

DIAGNOSIS:

SSN#: - -

PHYSICIAN

LAWRENCE HUBER, D.O.

REPORT:

CHEST: This survey demonstrates the pulmonary and cardiovascular structures to be within normal limits. Thoracic cage is symmetrical bilaterally, and free of gross pathology.

IMPRESSION: Unremarkable chest survey.

COPY

LE Huber  
6/31/97

THANK YOU FOR REFERRING THIS PATIENT

000013

Pharmacy Services

1 McKean, PA 16701

814-362-8900

400056853 Dr. D. OLSON 07/14/97  
JOHN, DEMETRIUS D. 21534-039  
APPLY TWICE A DAY ( PA HANDI )

OLHAFTATE 1% TOPICAL CREAM #1  
G 2 REFILLS EXPIRES 10/12/97

COPY

CI McKean  
P.O. Box 5000  
Radford, PA 16701

NAME: Brown, Demetrius

REG. NO.: 21534-039

600014

BP-S620.060 **PATIENT PROBLEM LIST** CDFAM  
AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

## PROBLEM LIST

[illegible]

ADVERSE / ALLERGIC  
DRUG REACTIONS  
(If none, record "No Known Drug Allergies")

NKDA

Patient Identification  
(Name, Reg #, DOB)

BROWN

DEMETRIUS

21534-039

B/M/O/02-08-1972

HT/509 WT/170 HR/BK EY/BN

CUSTODY/IN

form may be replicated via WP)

000015

5/8/72

### PROBLEM LIST (Continued)

[illegible]

Patient Identification  
(Name, Reg #, DOB)

600016

BP-5619.060 IMMUNIZATION RECORD CDFRM  
AUG 98

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

## TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
7/16/97	Connaught	24916-11	4/17/99	(L) deltoid	0.5cc/IM	Mutman	FCI McKean

## TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
7/16/97	Connaught	24916-12	2/1/98	(L) deltoid	0.1cc ID	Mutman/FCI McKean	7/16/97	0x0	Beard
7-8-98	Connaught	2486-11	10-99	RFA	5TH ID	C. Rymon, FCJ McKean	7-10-98	0x0	Beard
7/7/97	Connaught	2493-11	1/12/00	RFA	5TH ID	C. Rymon, FCJ McKean	7/9/99	0x0	Beard
7/11/00	Connaught	2499AA	9/17/02	RFA	5TH ID	C. Rymon, FCJ McKean	7/13/00	0x0	Mutman
5/6/01	Connaught	00630AA	5/15/02	RFA	0.1cc ID	C. Rymon, FCJ McKean	7/11/01	0x0	Beard
7/9/02	Aventis	00942AB	3/16/04	RFA	0.1cc ID	FCJ McKean	7/11/02	0x0	Beard
7/8/03	Park	0032P	9/03	RFA	0.1cc ID	FCJ McKean	7-10-03	0x0	Beard
6/29/04	Parkdale	00154P	08/05	LT. ARM	0.1cc ID	McKean	7/1/04	0	Beard
6/27/06	Aventis	0014AB	6/7/07	RFA	0.1/10	Liberty/RBK	6/29/04	0	Beard
6/27/06	Aventis	00220AA	6/10/07	RFA	0.1cc	Liberty/RBK	6/29/06	0	Beard

Patient Identification  
(Name, Reg #)

BROWN

DEMETRIUS

21534-039

B/M/O/02-08-1972

HT/509 WT/170

HR/BK

EY/BN

CUSTODY/IN

form may be replicated via WP)

000017

## HEPATITIS VACCINE

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

## INFLUENZA VACCINE

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

## OTHER (MMR, Polio, etc)

DATE	TYPE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION

Patient Identification  
(Name, Reg #)

000018

MEDICAL RECORD		REPORT OF MEDICAL EXAMINATION		DATE OF EXAM <i>6/25/03</i>
1. LAST NAME—FIRST NAME—MIDDLE NAME <i>Blawn Demetrius</i>		2. IDENTIFICATION NUMBER <i>21534-039</i>	3. GRADE AND COMPONENT OR POSITION	
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code) <i>16134 Greenview Detroit, MI. 48219</i>		5. EMERGENCY CONTACT (Name and address of contact) <i>Al Blawn 24329 Leewick Detroit, MI. 48219</i>		
6. DATE OF BIRTH <i>2/8/72</i>	7. AGE <i>31</i>	8. SEX <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/> MALE	9. RELATIONSHIP OF CONTACT <i>DAD</i>	
10. PLACE OF BIRTH <i>Detroit, MI.</i>		11. RACE <input type="checkbox"/> WHITE <input checked="" type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> HISPANIC WHITE <input type="checkbox"/> HISPANIC BLACK <input type="checkbox"/> ASIAN/PACIFIC ISLANDER		
12a. AGENCY <i>BOPDOJ</i>	12b. ORGANIZATION UNIT <i>FCI McKean</i>		13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY _____ b. CIVILIAN _____	
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS <i>U.S. MARSHAL P.O. Box 5000 Bradford, PA 16701</i>		15. RATING OR SPECIALTY OF EXAMINER		
		16. PURPOSE OF EXAMINATION <i>Bt Annually</i>		

17. CLINICAL EVALUATION				
NOR MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR MAL	NOR MAL	ABNOR MAL
<input checked="" type="checkbox"/>	A. HEAD, FACE, NECK AND SCALP		<input checked="" type="checkbox"/>	O. PROSTATE (Over 40 or clinically indicated)
<input checked="" type="checkbox"/>	B. EARS-GENERAL (INTERNAL CANALS) <i>Santanner</i> (Auditory acuity under items 39 and 40)		<input checked="" type="checkbox"/>	P. TESTICULAR
<input checked="" type="checkbox"/>	C. DRUMS (Perforation) <i>Tms start of rid.</i>		<input checked="" type="checkbox"/>	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)
<input checked="" type="checkbox"/>	D. NOSE <i>(+) DNS - RT</i>		<input checked="" type="checkbox"/>	R. ENDOCRINE SYSTEM
<input checked="" type="checkbox"/>	E. SINUSES		<input checked="" type="checkbox"/>	S. G-U SYSTEM
<input checked="" type="checkbox"/>	F. MOUTH AND THROAT <i>(+) Tonsils 1+ Smooth</i>		<input checked="" type="checkbox"/>	T. UPPER EXTREMITIES (Strength, range of motion)
<input checked="" type="checkbox"/>	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)		<input checked="" type="checkbox"/>	U. FEET
<input checked="" type="checkbox"/>	H. OPHTHALMOSCOPIC		<input checked="" type="checkbox"/>	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)
<input checked="" type="checkbox"/>	I. PUPILS (Equality and reaction)		<input checked="" type="checkbox"/>	W. SPINE, OTHER MUSCULOSKELETAL
<input checked="" type="checkbox"/>	J. OCULAR MOTILITY (Associated parallel movements nystagmus)		<input checked="" type="checkbox"/>	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS
<input checked="" type="checkbox"/>	K. LUNGS AND CHEST		<input checked="" type="checkbox"/>	Y. SKIN, LYMPHATICS
<input checked="" type="checkbox"/>	L. HEART (Thrust, size, rhythm, sounds)		<input checked="" type="checkbox"/>	Z. NEUROLOGIC (Equilibrium tests under item 41)
<input checked="" type="checkbox"/>	M. VASCULAR SYSTEM (Varicosities, etc.)		<input checked="" type="checkbox"/>	AA. PSYCHIATRIC (Specify any personality deviation)
<input checked="" type="checkbox"/>	N. ABDOMEN AND VISCERA (Include hernia)		<input checked="" type="checkbox"/>	BB. BREASTS
			<input checked="" type="checkbox"/>	CC. PELVIC (Females only)

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

*Neck - from, PLA, (+) TMT, & Bruits*

COPY

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES
<div style="display: flex; justify-content: space-between;"> <div> <div style="text-align: center;"> 0 1 2 3 Restorable 32 31 30 Teeth </div> <div style="text-align: center;"> 1 2 3 Non-restorable 32 31 30 teeth </div> <div style="text-align: center;"> X 1 2 3 Missing 32 31 30 Teeth </div> <div style="text-align: center;"> X X X 1 2 3 Replaced 32 31 30 by X X X Dentures </div> <div style="text-align: center;"> X 1 2 3 Fixed 32 31 30 Partial X Dentures </div> </div> </div>																
<div style="display: flex; justify-content: space-between;"> <div> <div style="text-align: center;"> 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 </div> <div style="text-align: center;"> L E F T </div> </div> </div>																

### 19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD (Place, date, film number and result)	
(2) URINE ALBUMIN	(4) MICROSCOPIC		
(3) URINE SUGAR			
C. SYPHILIS SEROLOGY (Specify test used and results)	D. EKG	E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS

600019

20. HEIGHT 5'10"		21. WEIGHT 170#		22. COLOR HAIR BRN		23. COLOR EYES BRN		24. BUILD <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		25. TEMPERATURE 98	
26. BLOOD PRESSURE (Arm at heart level)						27. PULSE (Arm at heart level)					
A. SITTING SYS. 138 DIAS. 74		B. RECUMBENT SYS. DIAS.		C. STANDING (5 mins.) SYS. DIAS.		A. SITTING 74		B. RECUMBENT RRE 12		C. STANDING (3 mins.) D. AFTER EXERCISE E. 2 MINS. AFTER	
28. DISTANT VISION 20/15 20/20						29. REFRACTION					
RIGHT 20/15		CORR. TO 20/		BY		S.		CX		CORR. TO BY	
LEFT 20/20		CORR. TO 20/		BY		S.		CX		CORR. TO BY	
31. HETEROPHORIA (Specify distance)											
ESO		EXO		R.H.		L.H.		PRISM DIV.		PRISM CONV. CT	
32. ACCOMMODATION		33. COLOR VISION (Test used and result)						34. DEPTH PERCEPTION (Test used and score)		UNCORRECTED	
RIGHT NL LEFT NL		OK								CORRECTED	
35. FIELD OF VISION		36. NIGHT VISION (Test used and score)						37. RED LENS TEST		38. INTRAOCULAR TENSION	
RIGHT NL LEFT NL		NE								RIGHT LEFT	
39. HEARING		40. AUDIOMETER						41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)			
RIGHT WV /15 SV /15		250 256 500 512 1000 1024 2000 2048 3000 2896 4000 4096 6000 6144 8000 8192									
LEFT WV /15 SV /15		RIGHT LEFT									

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

- WD/WV EHM  
 - Dental Services - 2 wks prior to all good & clearing & restoration required  
 - PPD done 7/8/03 - results pending Recd 7-10-03

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)						45A. PHYSICAL PROFILE					
Return PRV-Clinic @ Biannual H&P						P U L H E S					
46. EXAMINEE (Check)						45B. PHYSICAL CATEGORY					
A. <input checked="" type="checkbox"/> IS QUALIFIED FOR						A B C E					
B. <input type="checkbox"/> IS NOT QUALIFIED FOR											
47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER											
48. TYPED OR PRINTED NAME OF PHYSICIAN						SIGNATURE					
Robert C. Piotrowski, PA-C						Robert C. Piotrowski, PA-C					
49. TYPED OR PRINTED NAME OF PHYSICIAN						SIGNATURE					
D. Olson MD						D. Olson MD					
50. TYPED OR PRINTED NAME OF DENTIST OR PHARMACIAN (Indicate which)						SIGNATURE					
Director											
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY						SIGNATURE					

MEDICAL RECORD		REPORT OF MEDICAL EXAMINATION		DATE OF EXAM
1. LAST NAME-FIRST NAME-MIDDLE NAME <i>Brown, Demetrios</i>		2. IDENTIFICATION NUMBER <i>21534-039</i>		3. GRADE AND COMPONENT OR POSITION
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code) <i>16134 Greenview Detroit, MI. 48219</i>		5. EMERGENCY CONTACT (Name and address of contact) <i>Kimberly Mouse 16134 Greenview Det, MI. 48219</i>		
6. DATE OF BIRTH <i>2/8/72</i>	7. AGE <i>25</i>	8. SEX <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/> MALE	9. RELATIONSHIP OF CONTACT <i>Wife</i>	
10. PLACE OF BIRTH <i>Detroit</i>		11. RACE <input type="checkbox"/> WHITE <input checked="" type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> HISPANIC WHITE <input type="checkbox"/> HISPANIC BLACK <input type="checkbox"/> ASIAN/PACIFIC ISLANDER		
12a. AGENCY <i>RCP - DOX</i>		12b. ORGANIZATION UNIT <i>FCI McKean</i>		13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS <i>FCI McKean Box 5000 Blairstown, PA</i>		15. RATING OR SPECIALTY OF EXAMINER <i>A + D</i>		
16. PURPOSE OF EXAMINATION				

## 17. CLINICAL EVALUATION

NOR- MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR- MAL	NOR- MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR- MAL
<input checked="" type="checkbox"/>	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (Over 40 or clinically indicated)	
	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	<input checked="" type="checkbox"/>		P. TESTICULAR	<i>NE</i>
	C. DRUMS (Perforation)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
<input checked="" type="checkbox"/>	D. NOSE		<input checked="" type="checkbox"/>	R. ENDOCRINE SYSTEM	
<input checked="" type="checkbox"/>	E. SINUSES		<input checked="" type="checkbox"/>	S. G-U SYSTEM	
<input checked="" type="checkbox"/>	F. MOUTH AND THROAT		<input checked="" type="checkbox"/>	T. UPPER EXTREMITIES (Strength, range of motion)	
<input checked="" type="checkbox"/>	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)		<input checked="" type="checkbox"/>	U. FEET	
<input checked="" type="checkbox"/>	H. OPHTHALMOSCOPIC		<input checked="" type="checkbox"/>	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
<input checked="" type="checkbox"/>	I. PUPILS (Equality and reaction)			W. SPINE, OTHER MUSCULOSKELETAL	
<input checked="" type="checkbox"/>	J. OCULAR MOTILITY (Associated parallel movements nystagmus)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	<i>See #531</i> <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	K. LUNGS AND CHEST		<input checked="" type="checkbox"/>	Y. SKIN, LYMPHATICS	
<input checked="" type="checkbox"/>	L. HEART (Thrust, size, rhythm, sounds)			Z. NEUROLOGIC (Equilibrium tests under item 41)	
<input checked="" type="checkbox"/>	M. VASCULAR SYSTEM (Varicosities, etc.)			AA. PSYCHIATRIC (Specify any personality deviation)	<i>NE</i>
<input checked="" type="checkbox"/>	N. ABDOMEN AND VISCERA (Include hernia)			BB. BREASTS	<i>U/A</i>
				CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

*B + C impacted cerumen, TM not visualized.*

COPY

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																		REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES																																																																																											
<table border="0"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>Restorable</td><td>1</td><td>2</td><td>3</td><td>Non-restorable</td><td>1</td><td>2</td><td>3</td><td>Missing</td><td>X</td><td>X</td><td>X</td><td>Replaced by</td><td>1</td><td>2</td><td>3</td><td>Fixed Partial</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>Teeth</td><td>32</td><td>31</td><td>30</td><td>teeth</td><td>32</td><td>31</td><td>30</td><td>Teeth</td><td>32</td><td>31</td><td>30</td><td>Dentures</td><td>32</td><td>31</td><td>30</td><td>Dentures</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																		0	1	2	3	Restorable	1	2	3	Non-restorable	1	2	3	Missing	X	X	X	Replaced by	1	2	3	Fixed Partial	32	31	30	Teeth	32	31	30	teeth	32	31	30	Teeth	32	31	30	Dentures	32	31	30	Dentures																																																			
0	1	2	3	Restorable	1	2	3	Non-restorable	1	2	3	Missing	X	X	X	Replaced by	1	2	3	Fixed Partial																																																																																									
32	31	30	Teeth	32	31	30	teeth	32	31	30	Teeth	32	31	30	Dentures	32	31	30	Dentures																																																																																										
<table border="0"> <tr> <td>R</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>L</td> </tr> <tr> <td>I</td><td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td><td>E</td> </tr> <tr> <td>G</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>F</td> </tr> <tr> <td>H</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>T</td> </tr> <tr> <td>T</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																		R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L	I	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	E	G																	F	H																	T	T																			
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L																																																																																												
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T																																																																																																													

## 19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD (Place, date, film number and result)	
(2) URINE ALBUMIN	(4) MICROSCOPIC		
(3) URINE SUGAR			
C. SYPHILIS SEROLOGY (Specify test used and results)	D. EKG	E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS

000021

20. HEIGHT 5'9"		21. WEIGHT 174		22. COLOR HAIR black		23. COLOR EYES brown		24. BUILD <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		25. TEMPERATURE 97.6	
26. BLOOD PRESSURE (Arm at heart level)						27. PULSE (Arm at heart level)					
A. SITTING SYS. 116 DIA. 76		B. RECUMBENT SYS. DIA.		C. STANDING (5 mins.) SYS. DIA.		A. SITTING		B. RECUMBENT		C. STANDING (3 mins.)	
28. DISTANT VISION		CORR. TO 20/		BY		S.		CX		CORR. TO	
RIGHT 20/ 20		CORR. TO 20/		BY		S.		CX		CORR. TO	
LEFT 20/ 20		CORR. TO 20/		BY		S.		CX		CORR. TO	
31. HETEROPHORIA (Specify distance)											
ESO		EXO		R.H.		L.H.		PRISM DIV.		PRISM CONV. CT	
32. ACCOMMODATION		RIGHT		LEFT		33. COLOR VISION (Test used and result)		34. DEPTH PERCEPTION (Test used and score)		UNCORRECTED	
35. FIELD OF VISION		RIGHT		LEFT		36. NIGHT VISION (Test used and score)		37. RED LENS TEST		CORRECTED	
39. HEARING		RIGHT WW		/15 SV		/15		40. AUDIOMETER		41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)	
		LEFT WW		/15 SV		/15		250 256 500 512 1000 1024 2000 2048 3000 2896 4000 4096 6000 6144 8000 8192			
								RIGHT			
								LEFT			

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

1992 - Hand Fx and surgery done  
(R)

25 y/o, Black male  
non smoker  
NKDA  
Hx of STD - 1991 - treated  
no HIV test in the past

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

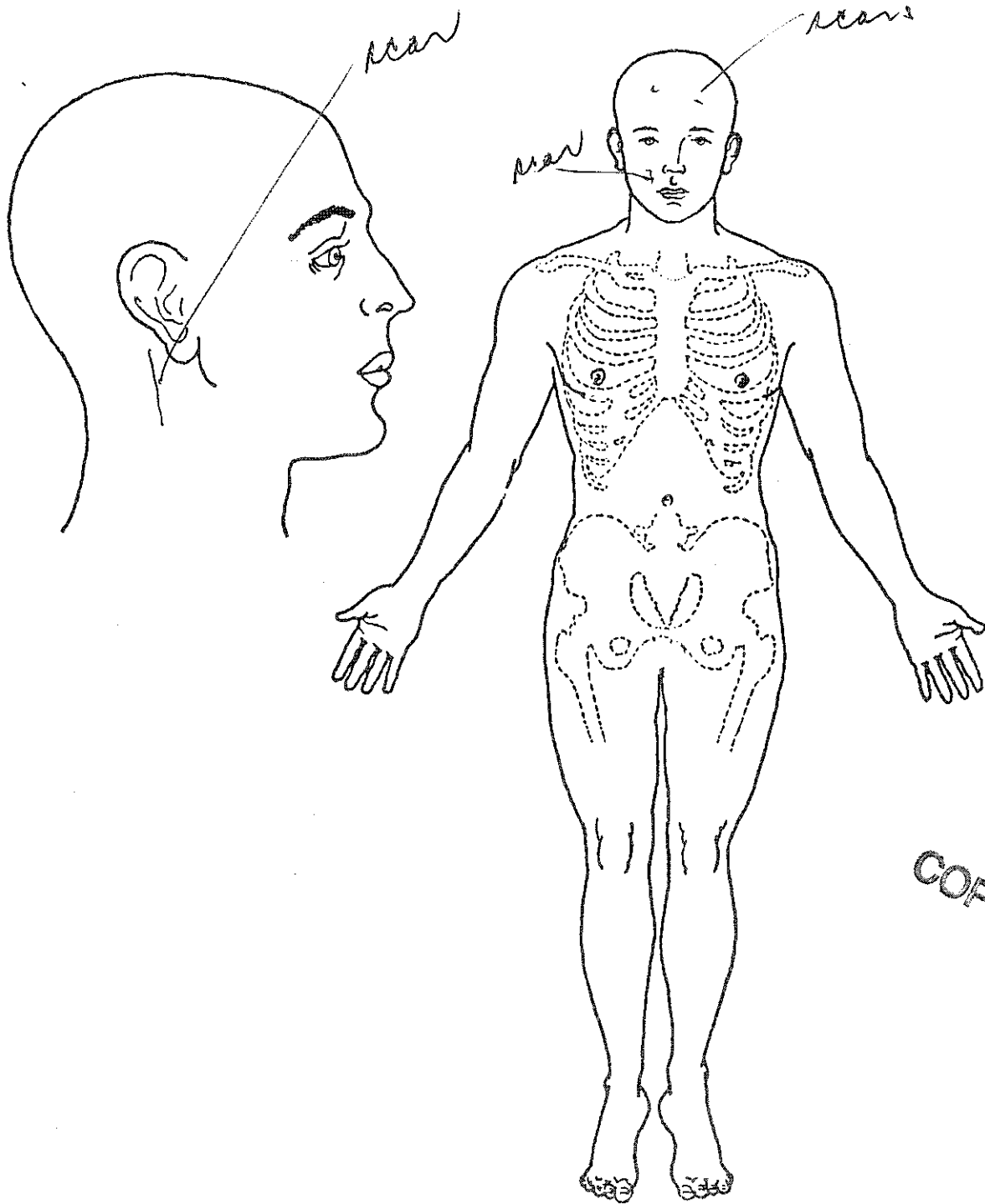
44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)						45A. PHYSICAL PROFILE					
						P U L H E S					
46. EXAMINEE (Check)						45B. PHYSICAL CATEGORY					
A. <input checked="" type="checkbox"/> IS QUALIFIED FOR											
B. <input type="checkbox"/> IS NOT QUALIFIED FOR											
47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER						A B C E					
48. TYPED OR PRINTED NAME OF PHYSICIAN						SIGNATURE					
M. TARR, MLP											
49. TYPED OR PRINTED NAME OF PHYSICIAN						SIGNATURE					
D. OLSON, MD											
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Specify which)						SIGNATURE					
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY						SIGNATURE					

531-110

NSN 7540-00-634-4274

MEDICAL RECORD

ANATOMICAL FIGURE



COPY

600023

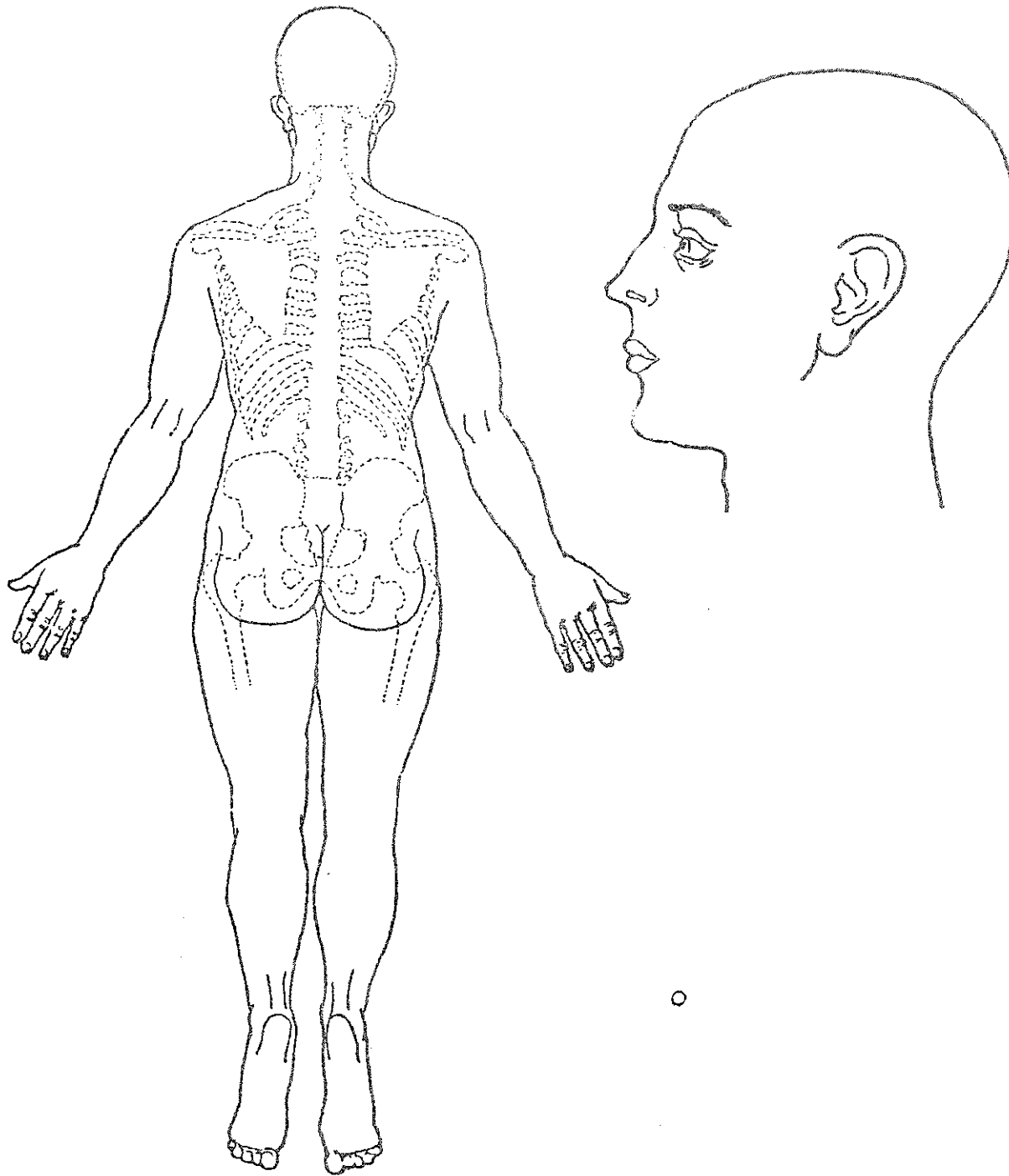
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)

REGISTER NO.

21534-039

WARD NO.

ANATOMICAL FIGURE



U.S. Department of Justice  
Federal Bureau Of Prisons

# MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY  
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME

BROWN DEMETRIUS DUANE

2. REGISTER NUMBER

21534-039

3. PURPOSE OF EXAMINATION

INTAKE

4. DATE OF EXAMINATION

11-4-09

5. EXAMINING FACILITY

FBI Raybrook

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

NO MEDICATION

NKDA

Denial PAIN

COPY

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lived with anyone who had tuberculosis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Coughed up blood
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bled excessively after injury or tooth extraction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Attempted suicide
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear glasses or contact lenses
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Have vision in both eyes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear a hearing aid
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stutter or stammer habitually
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to serum drug or medicine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Epilepsy or fits
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rupture/hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Piles or rectal disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose, or throat trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had homosexual contact?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Been exposed to AIDS
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe tooth or gum trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	VD—Syphilis, gonorrhea, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Alcohol Use (Excessive)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Drug Use/Addiction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, or Bursitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Marijuana
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cocaine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lameness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heroin
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	L.S.D.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Painful or "Trick" shoulder or elbow	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Amphetamines
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Others: (Specify)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neuritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Withdrawal Problems
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Paralysis (include infantile)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

10. FEMALES ONLY HAVE YOU EVER

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been treated for a female disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Had a change in menstrual pattern
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☒ Discharged ☐ Inmate

000025

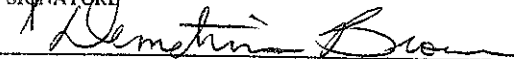
CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW					
YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	✓	D. Other medical reasons (If yes, give reasons.)		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	✓	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details.)		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
	✓	15. Have you ever been denied life insurance? (If yes, state reason and give details.)			
	✓	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			
	✓	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)			

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE



INTAKE SCREENING:

 INMATE RECEIVED FROM: COURT \_\_\_\_\_ TRANSFER \_\_\_\_\_ P.V. \_\_\_\_\_  
 OTHER \_\_\_\_\_

 THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS  
 OR ALCOHOL? \_\_\_\_\_

 MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE  
 DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE,  
 APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES,  
 JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORM-  
 ITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

 DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL  
 STAFF YES \_\_\_\_\_ NO \_\_\_\_\_

WHAT ARRANGEMENTS HAVE BEEN MADE? \_\_\_\_\_

 IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH,  
 HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE

DUTY STATUS: TEMPORARY WORK \_\_\_\_\_ RESTRICTED \_\_\_\_\_

GENERAL POPULATION \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

TYPE AND EXTENT OF LIMITATION \_\_\_\_\_

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

neg IB  
 not HIV/Hepatitis tested  
 neg TB test  
 neg IVDU  
 neg lice

neg suicidal ideation  
 HX VD 1994

600026

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

K. BURDO, RN

DATE

11/11/04

SIGNATURE



NUMBER OF ATTACHED SHEETS

J.S. Department of Justice

Fédéral Bureau Of Prisons

## MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY  
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME

Demetrius Brown AKA. Darius Duane Nixon

2. REGISTER NUMBER

21534-039

3. PURPOSE OF EXAMINATION

4. DATE OF EXAMINATION

JUN 19 1997

5. EXAMINING FACILITY

Intake Screening  
Federal Transfer Center, OK.

6. STATEMENT OF INMATE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

COPY

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lived with anyone who had tuberculosis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Coughed up blood
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bled excessively after injury or tooth extraction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Attempted suicide
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear glasses or contact lenses
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Have vision in both eyes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear a hearing aid
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stutter or stammer habitually
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to serum drug or medicine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Epilepsy or fits
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rupture/hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Piles or rectal disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose, or throat trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had homosexual contact?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Been exposed to AIDS
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe tooth or gum trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	VD—Syphilis, gonorrhea, etc.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use (Excessive)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Drug Use/Addiction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, or Bursitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cocaine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lameness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heroin
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	L.S.D.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Painful or "Trick" shoulder or elbow	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Amphetamines
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Others: (Specify)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neuritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Withdrawal Problems
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Paralysis (include infantile)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

10. FEMALES ONLY HAVE YOU EVER

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been treated for a female disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Had a change in menstrual pattern
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☒ Right handed ☐ Left handed

600027

CHECK EACH ITEM YES		EVERY ITEM CHECKED YES MUST BE FULLY EL.	NED IN BLANK SPACE BELOW		
YES	NO		YES	NO	
	<input checked="" type="checkbox"/>	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		<input checked="" type="checkbox"/>	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	<input checked="" type="checkbox"/>	B. Inability to perform certain motions.		<input checked="" type="checkbox"/>	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	<input checked="" type="checkbox"/>	C. Inability to assume certain positions.		<input checked="" type="checkbox"/>	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	<input checked="" type="checkbox"/>	D. Other medical reasons (If yes, give reasons.)		<input checked="" type="checkbox"/>	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	<input checked="" type="checkbox"/>	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details.)		<input checked="" type="checkbox"/>	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
	<input checked="" type="checkbox"/>	15. Have you ever been denied life insurance? (If yes, state reason and give details.)		<input checked="" type="checkbox"/>	
	<input checked="" type="checkbox"/>	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		<input checked="" type="checkbox"/>	

EXPLANATION: (#13-22 ABOVE)

I was a patient at Grace Hospital in Detroit due to a Head Injury and a hand fracture.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

Demetrius Brown

SIGNATURE

Demetrius Brown

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT \_\_\_\_\_ TRANSFER ☒ P.V. \_\_\_\_\_

OTHER \_\_\_\_\_

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? No

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES \_\_\_\_\_ NO ☒

WHAT ARRANGEMENTS HAVE BEEN MADE? \_\_\_\_\_

DUTY STATUS: TEMPORARY WORK \_\_\_\_\_ RESTRICTED \_\_\_\_\_

GENERAL POPULATION \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

TYPE AND EXTENT OF LIMITATION \_\_\_\_\_

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

*W. K. M. J.*  
*D. C. J.*

600028

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER: Russell Roberts NR EMT-P  
Federal Transfer Center. OK

DATE: JUN 19 1997 SIGNATURE: *[Signature]*

NUMBER OF ATTACHED SHEETS

Federal Bureau Of Prisons

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY  
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME

BROWN Demetrius

2. REGISTER NUMBER

21534-037

3. PURPOSE OF EXAMINATION

1/S

4. DATE OF EXAMINATION

06/30/97

5. EXAMINING OFFICE

LEWISBURG  
HEALTH SERVICES UNIT  
LEWISBURG, PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

COPY

7. HAVE YOU EVER (Please check each item)

YES NO

(Check each item)

☒ Lived with anyone who had tuberculosis☒ Coughed up blood☒ Bled excessively after injury or tooth extraction☒ Attempted suicide☒ Been a sleepwalker

8. DO YOU (Please check each item)

YES NO

(Check each item)

☒ Wear glasses or contact lenses☒ Have vision in both eyes☒ Wear a hearing aid☒ Stutter or stammer habitually☒ Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES NO DON'T KNOW

(Check each item)

YES NO DON'T KNOW

(Check each item)

YES NO DON'T KNOW

(Check each item)

☒ Scarlet fever☒ Rheumatic fever☒ Swollen or painful joints☒ Frequent or severe headache☒ Dizziness or fainting spells☒ Eye trouble☒ Ear, nose, or throat trouble☒ Hearing loss☒ Chronic or frequent colds☒ Severe tooth or gum trouble☒ Sinusitis☒ Hay Fever☒ Head injury☒ Skin diseases☒ Thyroid trouble☒ Tuberculosis☒ Asthma☒ Shortness of breath☒ Pain or pressure in chest☒ Chronic cough☒ Palpitation or pounding heart☒ Heart trouble☒ High or low blood pressure☒ Cramps in your legs☒ Frequent indigestion☒ Stomach, liver, or intestinal trouble☒ Gall bladder trouble or gallstones☒ Jaundice or hepatitis☒ Adverse reaction to serum drug or medicine☒ Broken bones☒ Tumor, growth, cyst, cancer☒ Rupture/hernia☒ Piles or rectal disease☒ Frequent or painful urination☒ Bed wetting since age 12☒ Kidney stone or blood in urine☒ Sugar or albumin in urine☒ VD—Syphilis, gonorrhea, etc.☒ Recent gain or loss of weight☒ Arthritis, Rheumatism, or Bursitis☒ Bone, joint or other deformity☒ Lameness☒ Loss of finger or toe☒ Painful or "Trick" shoulder or elbow☒ Recurrent back pain☒ "Trick" or locked knee☒ Foot trouble☒ Neuritis☒ Paralysis (include infantile)☒ Epilepsy or fits☒ Car, train, sea or air sickness☒ Frequent trouble sleeping☒ Depression or excessive worry☒ Loss of memory or amnesia☒ Nervous trouble of any sort☒ Periods of unconsciousness☒ Have you ever had homosexual contact?☒ Been exposed to AIDS☒ Alcohol Use (Excessive)☒ Drug Use/Addiction☒ Marijuana☒ Cocaine☒ Heroin☒ L.S.D.☒ Amphetamines☒ Others: (Specify)☒ Alcohol or drug☒ Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

☒ Been treated for a female disorder☒ Had a change in menstrual pattern☒ ARE YOU PREGNANT☒ SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

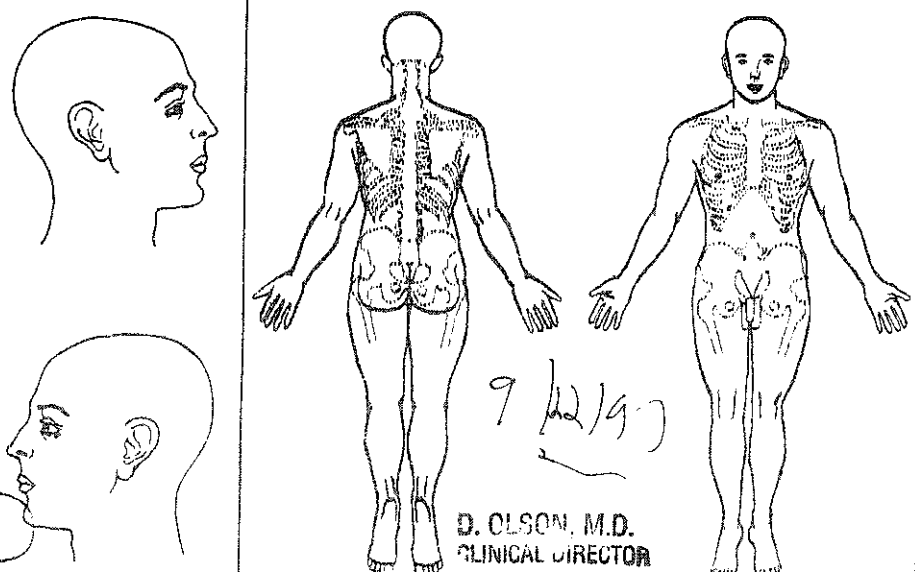
☒ Right handed ☐ Left handed

600029

CHECK EACH ITEM YES		NO EVERY ITEM CHECKED YES MUST BE FULLY		AINED IN BLANK SPACE BELOW		
YES	NO			YES	NO	
	<input checked="" type="checkbox"/>	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			<input checked="" type="checkbox"/>	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	<input checked="" type="checkbox"/>	B. Inability to perform certain motions.			<input checked="" type="checkbox"/>	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	<input checked="" type="checkbox"/>	C. Inability to assume certain positions.			<input checked="" type="checkbox"/>	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	<input checked="" type="checkbox"/>	D. Other medical reasons (If yes, give reasons.)			<input checked="" type="checkbox"/>	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	<input checked="" type="checkbox"/>	14. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)			<input checked="" type="checkbox"/>	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
	<input checked="" type="checkbox"/>	15. Have you ever been denied life insurance? (If yes, state reason and give details.)				
	<input checked="" type="checkbox"/>	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)				
	<input checked="" type="checkbox"/>	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)				
EXPLANATION: (#13-22 ABOVE) <i>1992 Detroit Grace Hosp. Hand fracture R.H.</i>						
I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.						
TYPED OR PRINTED NAME OF EXAMINEE <i>Demetrius Brown</i>				SIGNATURE <i>Demetrius Brown</i>		
INTAKE SCREENING: INMATE RECEIVED FROM: COURT _____ TRANSFER <input checked="" type="checkbox"/> P.V. _____ OTHER _____				THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? <i>NO</i>		
MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.				DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES _____ NO <input checked="" type="checkbox"/>		
IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE				WHAT ARRANGEMENTS HAVE BEEN MADE? <i>none</i>		
23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)				DUTY STATUS: TEMPORARY WORK _____ RESTRICTED <i>NO</i>		
Medications _____ Yes <input checked="" type="checkbox"/> No Allergies _____ Yes <input checked="" type="checkbox"/> No Medical Complaints _____ Yes <input checked="" type="checkbox"/> No Evidence of Lice _____ Yes <input checked="" type="checkbox"/> No Hx of IV Drug Use _____ Yes <input checked="" type="checkbox"/> No Suicidal Thoughts _____ Yes <input checked="" type="checkbox"/> No				GENERAL POPULATION _____ YES _____ NO <i>NO</i> TYPE AND EXTENT OF LIMITATION <i>NO</i>		
<i>I'm Request no pork diet.</i>						
TYPED OR PRINTED NAME OF EXAMINER <i>plain Hillework, PA</i> <i>plain Hillework, PA</i>				DATE <i>06/30/97</i>		SIGNATURE <i>P. Hillework, PA</i>
REVERSE				NUMBER OF ATTACHED SHEETS <i>600030</i>		

U.S. DEPARTMENT OF JUSTICE  
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP  
(Medical)

1. Institution <i>FEE MEKEAN</i>		2. Name of Injured <i>BROWN THOMAS</i>		3. Register Number <i>421 34-061</i>	
4. Injured's Duty Assignment <i>Union</i>		5. Housing Assignment <i>1B</i>		6. Date and Time of Injury <i>9/19/97 1820</i>	
7. Where Did Injury Happen (Be specific as to location) <i>union</i>			Work Related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. Date and Time Reported for Treatment <i>9/19/97 1830</i>
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) <i>Scraping a board with putty knife &amp; slip &amp; went into my hand</i>  <i>Thomas Brown</i> Signature of Patient					
10. Objective: (Observations or Findings from Examination) <i>0.5 cm superficial wound</i> <i>a scratch like</i>			X-Rays Taken <input type="checkbox"/> Not Indicated <input checked="" type="checkbox"/> X-Ray Results		
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) <i>superficial wound</i>					
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) <i>1. apply Butterfly and Band Aid after cleaning the wound</i>					
13. This Injury Required:  <input checked="" type="checkbox"/> a. No Medical Attention <input type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain)  <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician  <i>D. Olson</i> Signature of Physician or Physician Assistant		 <p><i>9/21/97</i> D. OLSON, M.D. CLINICAL DIRECTOR</p>			

Original - Medical File

Canary - Safety

Pink - Work Supervisor (Work related only)

Self Carboned Form - If ballpoint pen is used, PRESS HARD

000031

## CLINICAL RECORD

## DENTAL TREATMENT RECORD (Continuation)

DATE \_\_\_\_\_

DIAGNOSIS - TREATMENT - REMARKS

SIGNATURE

07/13/04  
1007 hrs

P: Admitted patient to assessment and patient under study.

*[Handwritten signature]*

~~William K. Collins, D.D.S.~~  
~~CDO~~  
~~FCI McKean~~

~~COPY~~

Continued On Reverse Side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

REGISTER NO. 21534-039

WARD NO.

Brown, Demetrius

FCI McKean

**DENTAL TREATMENT RECORD**  
HRSA-237 (4/95)

600032

**THE ADJUTANT**

[illegible]

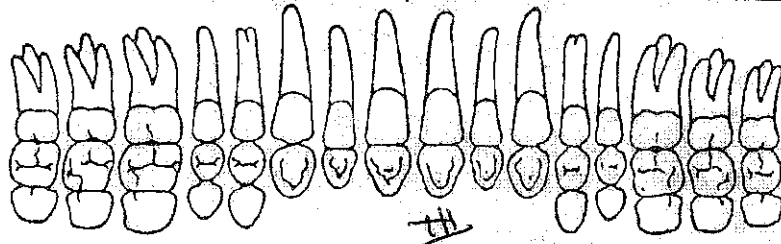
600033

BP-S618.060 CLINICAL DENTAL RECORD CDFRM  
AUG 96

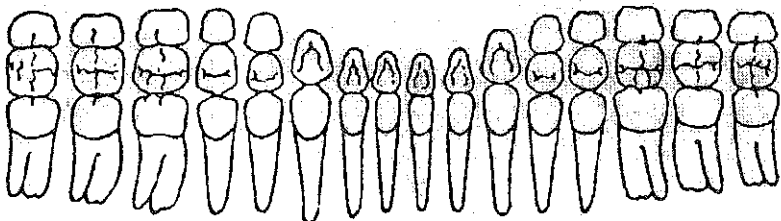
U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

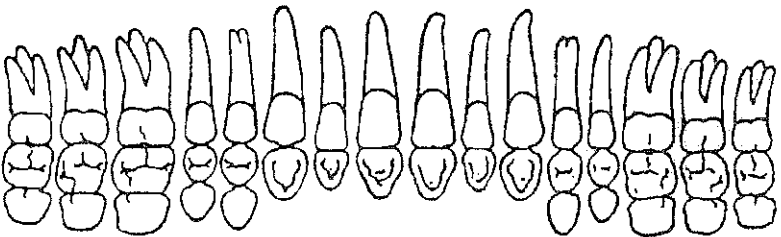
Examination: ☐ Screening ☒ Comprehensive ☐ Periodic



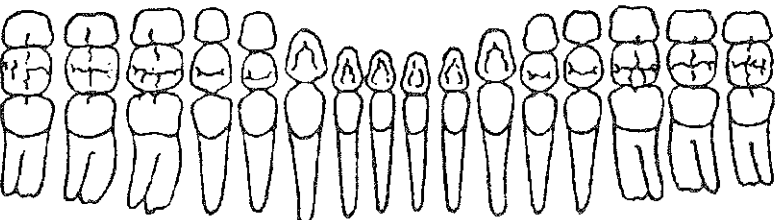
RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT  
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Treatment Completed



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT  
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Occlusion

Class I

Oral Hygiene

Good

Fair

Poor

CPITN

3 2 3

Head & Neck/Soft Tissue

STWOL

Additional Findings

# 9 class III  
Mobility  
HX of injury

D: \_\_\_\_\_

M: \_\_\_\_\_

F: \_\_\_\_\_

Recommended Treatment Plan

☒ Radiographs 9-9-04

PH 9

98VBWx4

☒ Dental Prophylaxis

☒ Oral Hygiene Instruction

9-9-04

☐ Periodontal Evaluation 0 I II III

☐ Oral Surgical Procedures

☐ Endodontic

☐ Restorative

COPY

☐ Prosthodontic Evaluation

Patient Name

Brown,  
Demetrius

Number

21531-039

Sex: M F

Age:

32

2-8-72

FCI McKean

Dentist Signature

Date

W. K. Collins, DDS

CDO

FCI McKean

99-04

000034

## Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
09/04/04 1000hrs		<p>SOA: Lt Carept</p> <p>P: Comp HH, soft tissue exam, assessment, VAW=4. Pt presents w/ #9 class III mobility and localized recession of #9. Hx of injury. Pt of #9 talon. Pt scheduled to see Dr. Collins for review of PAX. Pt presents w/ heavy calc + stain throughout. Ultrasonic BI-4, selective hand scale, polish, OTT, Next: Comp Exam</p> <p>J. Schmalz RDH J.L. Schmalz RDH FCI McKean</p> <p>W. K. Collins, DDS CDO FCI McKean</p>
09/13/04 1007hrs		<p>5- "I was playing basketball in 1997 and was hit in the mouth with an elbow."</p> <p>P: #10</p> <p>O: Med Hx: NKDA</p> <p>Pt. referred by D.H. re: Mobility of #09</p> <p>#09 Injured in 1997</p> <p>#09, +1/2 Mobility, (-) Night pain, (-) Pain on Chewing, (-) Sweets, (-) Hot/Cold, (-) Caries</p> <p>PAX: Bone loss around #09 on D.</p> <p>A: #09, Periodontal disease; poor root configuration (cone shaped); poor prognosis</p> <p>William K. Collins, D.D.S. CDO FCI McKean</p>

600035

Language template provided in Spanish \_\_\_\_\_, or English

Are you currently taking any medication? If so, what? <u>NO</u>	YES	<input checked="" type="checkbox"/> NO
Are you allergic to or have you had a reaction to any medication or drug? If so, what?	YES	<input checked="" type="checkbox"/> NO
Have you been under the care of a physician during the past two years? If so, why?	YES	<input checked="" type="checkbox"/> NO
Have you been hospitalized in the past two years? If so, why?	YES	<input checked="" type="checkbox"/> NO
Do you have or have you ever had a heart murmur or been treated for a heart condition?	YES	<input checked="" type="checkbox"/> NO
Have you ever been treated for a tumor, growth, or cancer?	YES	<input checked="" type="checkbox"/> NO
Have you ever had excessive or prolonged bleeding as a result of a medical condition or medication (ex. Hemophilia or blood thinners)?	YES	<input checked="" type="checkbox"/> NO
Do you have a latex allergy?	YES	<input checked="" type="checkbox"/> NO
Do you currently use tobacco products?	YES	<input checked="" type="checkbox"/> NO
WOMEN ONLY: Are you pregnant?	YES	<input type="checkbox"/> NO

Check any of the following that you have had:

<input type="checkbox"/> Congenital heart defects	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Heart attack or heart problems	<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis (HA HB HC)	<input type="checkbox"/> AIDS or HIV infection
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Any type of transplant	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Steroid treatment	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Anemia (blood problems)	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Angina	<input type="checkbox"/> Artificial joint
<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Radiation therapy
<input checked="" type="checkbox"/> STD (syphilis, gonorrhea, herpes)	<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Asthma
<input type="checkbox"/> Angio edema	<input type="checkbox"/> Glucose - 6-phosphate dehydrogenase deficiency	

Do you have any disease, condition, or problem not listed?

Check any of the following that you have had or applies to you:

<input checked="" type="checkbox"/> Sensitive teeth	<input type="checkbox"/> Unusual sounds while eating	<input type="checkbox"/> Burning tongue
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Snoring	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Food impaction	<input type="checkbox"/> Blisters on lips or mouth	<input type="checkbox"/> Decayed teeth
<input type="checkbox"/> Pain around ear	<input type="checkbox"/> Clenching or grinding	<input checked="" type="checkbox"/> Loose teeth
<input type="checkbox"/> Tooth ache	<input type="checkbox"/> Swelling or lumps in mouth/throat	<input type="checkbox"/> Wear dentures
<input type="checkbox"/> Wear partial dentures		

Printed Name: <u>Demetrius Brown</u>	Signature: <u>Demetrius Brown</u>
No.: <u>21534-039</u>	Institution: <u>FCI McKean</u>
Date: <u>9/9/04</u>	Updated:

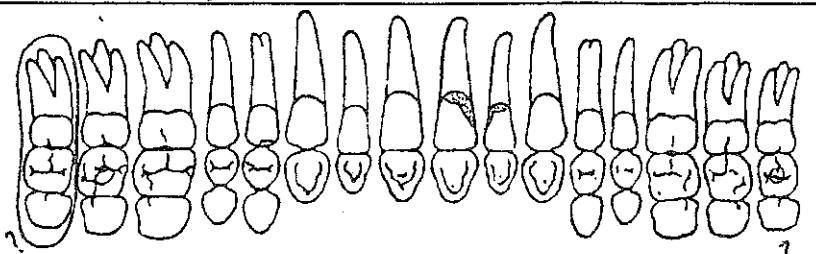
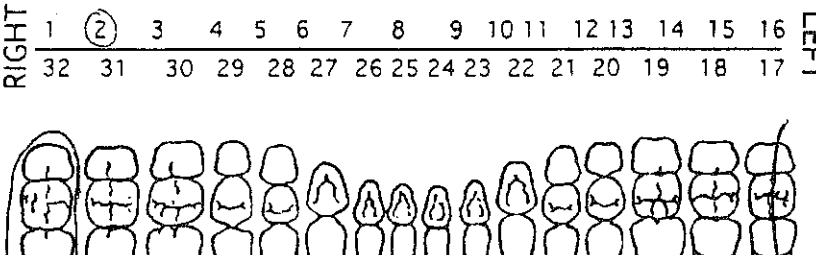
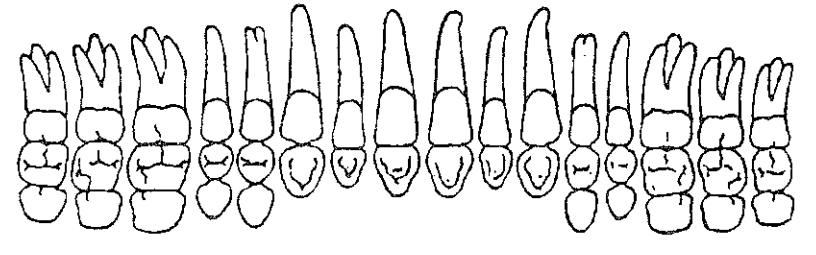
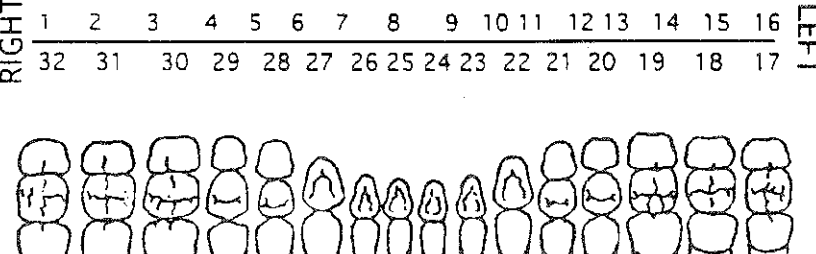
(This form may be replicated via WP)

600036

BP-S618.060 CLINICAL DENTAL RECORD CDFRM  
AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

Examination: <input checked="" type="checkbox"/> Screening <input type="checkbox"/> Comprehensive <input type="checkbox"/> Periodic		Occlusion Class I edge-edge #10 + #23 open bite #7 + #27						
		Oral Hygiene Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor <input type="checkbox"/>						
		CPITN <table border="1"> <tr> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>2</td> <td>2</td> <td>2</td> </tr> </table>	2	2	2	2	2	2
2	2	2						
2	2	2						
Head & Neck/Soft Tissue STWNL		Additional Findings scars : above @ eye inside @ eye below @ ear on bridge of nose TBA : *3, *4, *5, *8, *12, *13, *1 *20, *21, *22, *23, *24, *25 *26, *27, *28, *29, *30, *3						
Treatment Completed 		Recommended Treatment Plan <input checked="" type="checkbox"/> Radiographs <input checked="" type="checkbox"/> Dental Prophylaxis <input checked="" type="checkbox"/> Oral Hygiene Instruction <input type="checkbox"/> Periodontal Evaluation 0   I   II   III <input type="checkbox"/> Oral Surgical Procedures <input type="checkbox"/> Endodontic <input checked="" type="checkbox"/> Restorative #2 0						
		<input type="checkbox"/> Prosthodontic Evaluation						
Patient Name: Brown, Demetrius Number: 21534-039 Sex: (M) F Age: 31 2/08/72		Dentist Signature: W. K. Collins, DDS Date: 6/25/03 CDO FCI McKean						

[illegible]

600038

September 15, 1996  
Attachment IV-E, Page 1FEDERAL BUREAU OF PRISONS  
DENTAL/MEDICAL HEALTH HISTORY FORM

1. Are you currently taking any medication?  
If so, what? \_\_\_\_\_ yes ☒ no
2. Are you allergic to or have you had a reaction  
to any medication or drug? If so, what? \_\_\_\_\_ yes ☒ no
3. Have you been under the care of a physician during  
the past two years? If so, why? \_\_\_\_\_ yes ☒ no
4. Have you been hospitalized in the past two years?  
If so, why? \_\_\_\_\_ yes ☒ no
5. Do you have or have you ever had a heart murmur  
or been treated for a heart condition? yes ☒ no
6. Do your ankles ever swell during the day? yes ☒ no
7. Have you ever been treated for a tumor or growth? yes ☒ no
8. Have you ever had abnormal bleeding? yes ☒ no
9. Have you ever had serious difficulty with any  
dental treatment? yes ☒ no
10. Have you ever had clicking, popping, or pain  
in your jaw joint? rt side ☒ yes ☐ no

Circle any of the following that you have had:

Congenital heart defects	Heart murmur
Heart attack or heart problems	Angina
Stroke	High Blood pressure
Rheumatic Fever	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia (blood problems)	Diabetes
Thyroid problems	AIDS or HIV infection
Chronic bronchitis	Emphysema
Venereal disease (syphilis, gonorrhea)	Tuberculosis (TB)
Arthritis	Psychiatric treatment
Artificial heart valve	Artificial joint
Hepatitis	

Do you currently use tobacco (cigarettes, chewing tobacco,  
snuff)? yes ☒ no

Do you have any disease, condition, or problem not listed?

WOMEN ONLY: Are you pregnant? noName: Demetrius BrownReg No. 21534-039Institution: FCI McKeanDate: 6/25/03

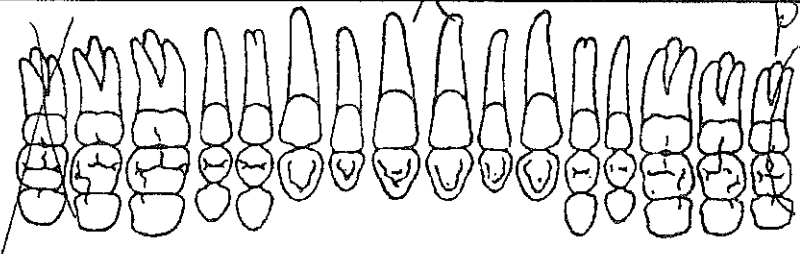
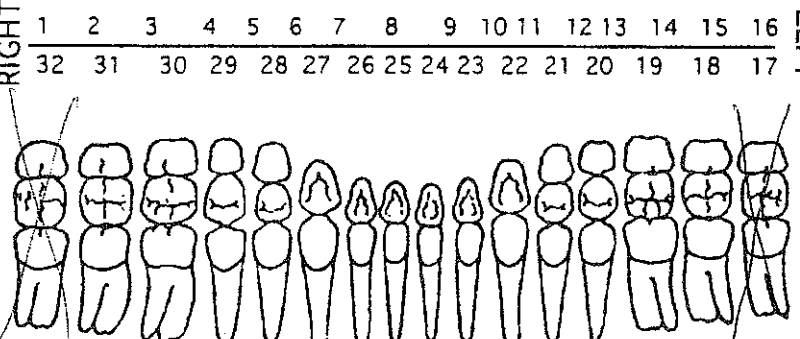
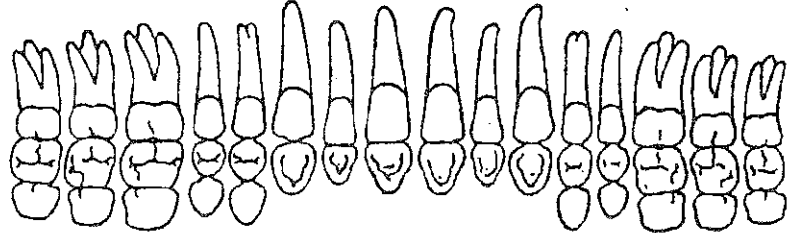
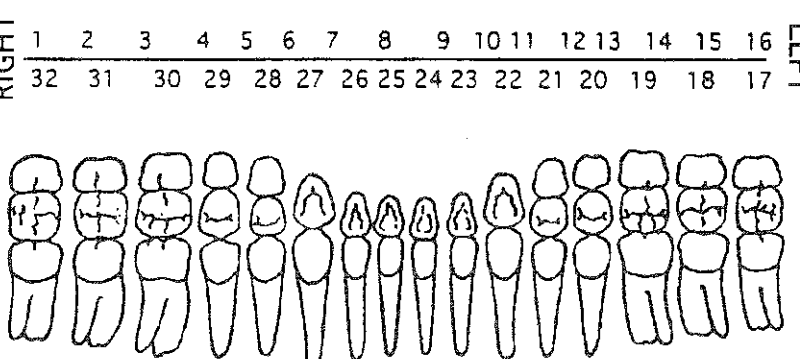
600039

BP-S618.060 CLINICAL DENTAL RECORD CDFRM

AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

Examination: <input type="checkbox"/> Screening <input checked="" type="checkbox"/> Comprehensive <input type="checkbox"/> Periodic		Occlusion <u>WNL</u>						
		Oral Hygiene <u>Good</u> Fair Poor						
		CPITN <table border="1"><tr><td>1</td><td>1</td><td>1</td></tr><tr><td>1</td><td>2</td><td>2</td></tr></table>	1	1	1	1	2	2
1	1	1						
1	2	2						
Head & Neck/Soft Tissue <u>STWNL</u>		Additional Findings						
Treatment Completed		Recommended Treatment Plan						
		<input checked="" type="checkbox"/> Radiographs <u>BWS 12-1-97</u>						
		<input checked="" type="checkbox"/> Dental Prophylaxis <u>12-1-97</u> <input checked="" type="checkbox"/> Oral Hygiene Instruction <input checked="" type="checkbox"/> Periodontal Evaluation 0 I <u>(II)</u> III <u>12-2-97</u>						
Patient Name <u>Brown, Demetrius</u> Number <u>21534-039</u> Sex: <u>(M)</u> F Age: <u>25</u>		<input type="checkbox"/> Oral Surgical Procedures <input type="checkbox"/> Endodontic <input type="checkbox"/> Restorative <input type="checkbox"/> Prosthodontic Evaluation						

Brown, Demetrius  
 21534-039  
 FCI McKeen

Dentist Signature

Date

W. J. Williams 12-1-97  
 600040

Federal Bureau of Prisons Clinical Dental Records

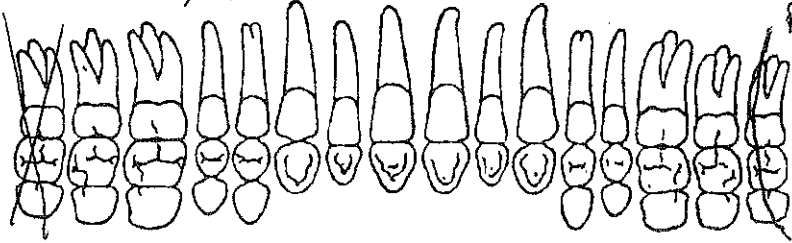
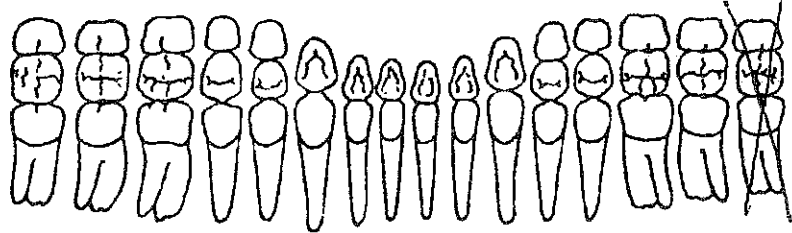
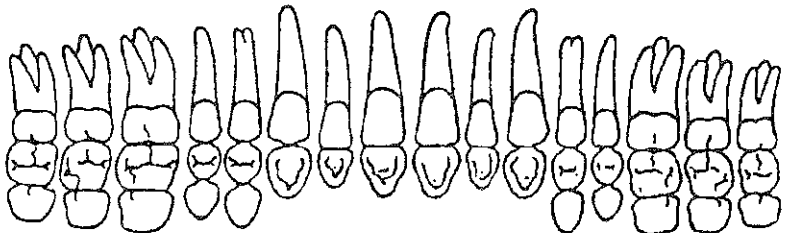
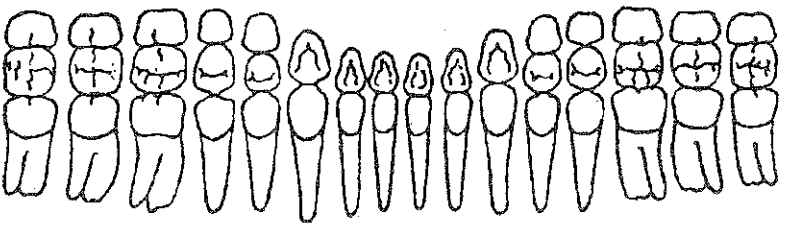
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BP-S618.060 CLINICAL DENTAL RECORD CDFRM  
AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

Examination: <input checked="" type="checkbox"/> Screening <input type="checkbox"/> Comprehensive <input type="checkbox"/> Periodic		Occlusion <i>WNL</i>						
		Oral Hygiene <input checked="" type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor						
		CPITN <table border="1"> <tr> <td>1</td> <td>1</td> <td>1</td> </tr> <tr> <td>1</td> <td>2</td> <td>1</td> </tr> </table>	1	1	1	1	2	1
1	1	1						
1	2	1						
Head & Neck/Soft Tissue <i>STWNL</i>		Additional Findings D: <i>Ø</i> DM: <i>2</i> M: <i>Ø</i> F: <i>Ø</i>						
Treatment Completed		Recommended Treatment Plan <input checked="" type="checkbox"/> Radiographs <i>BWS</i>						
		<input checked="" type="checkbox"/> Dental Prophylaxis <input checked="" type="checkbox"/> Oral Hygiene Instruction <input checked="" type="checkbox"/> Periodontal Evaluation 0 I II III <i>7-16-97</i>						
		<input type="checkbox"/> Oral Surgical Procedures <input type="checkbox"/> Endodontic <input type="checkbox"/> Restorative <input type="checkbox"/> Prosthetic Evaluation						
Patient Name <i>Brown, Demetrius</i> <i>21534-039</i> <i>FE I McKeen</i>		Number Sex: <input checked="" type="radio"/> M <input type="radio"/> F Age: <i>25</i>						

Dentist Signature

Date

*David Harris*

*7-16-97*  
*666042*

DAVID HARRIS  
CHIEF DENTAL OFFICE

Federal Bureau of Prisons Clinical Dental Records

[illegible]

DAVID HARRIS, D.D.S.  
CHIEF DENTAL OFFICER

000043

1. Are you currently taking any medication?  
If so, what? \_\_\_\_\_ yes ☒ no
2. Are you allergic to or have you had a reaction  
to any medication or drug? If so, what?  
\_\_\_\_\_ yes ☒ no
3. Have you been under the care of a physician during  
the past two years? If so, why? \_\_\_\_\_ yes ☒ no
4. Have you been hospitalized in the past two years?  
If so, why? \_\_\_\_\_ yes ☒ no
5. Do you have or have you ever had a heart murmur  
or been treated for a heart condition? yes ☒ no
6. Do your ankles ever swell during the day? yes ☒ no
7. Have you ever been treated for a tumor or growth? yes ☒ no
8. Have you ever had abnormal bleeding? yes ☒ no
9. Have you ever had serious difficulty with any  
dental treatment? yes ☒ no

CC-0

- Congenital heart defects
- Heart attack or heart problems
- Stroke
- Rheumatic Fever
- Asthma
- Anemia (blood problems)
- Thyroid problems
- Chronic bronchitis
- Venereal disease (syphilis, gonorrhea)
- Arthritis
- Artificial heart valve
- Hepatitis

- Heart murmur
- Angina
- High Blood pressure
- Heart pacemaker
- Epilepsy or seizures
- Diabetes
- AIDS or HIV infection
- Emphysema
- Tuberculosis (TB)
- Psychiatric treatment
- Artificial joint

Do you have any disease, condition, or problem not listed?  
WOMEN ONLY: Are you pregnant?

Name: Debra Ann Johnson

Reg No. 31534-039

000044